(e) *Exceptions.* Limits established under this section may be adjusted upward for a SNF or HHA under the circumstances specified in paragraphs (e)(1) through (e)(5) of this section. An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the SNF or HHA, and verified by the intermediary.

(1) *Atypical services.* The SNF or HHA can show that the—

(i) Actual cost of services furnished by a SNF or HHA exceeds the applicable limit because the services are atypical in nature and scope, compared to the services generally furnished by SNFs or HHAs similarly classified; and

(ii) Atypical services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

(2) *Extraordinary circumstances.* The SNF or HHA can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or other unusual occurrences with substantial cost effects.

(3) *Areas with fluctuating populations.* The SNF meets the following conditions:

(i) Is located in an area (for example, a resort area) that has a population that varies significantly during the year.

(ii) Is furnishing services in an area for which the appropriate health planning agency has determined does not have a surplus of beds or similar services and has certified that the beds or similar services furnished by the SNF are necessary.

(iii) Meets occupancy or capacity standards established by the Secretary.

(4) *Medical and paramedical education.* The SNF or HHA can demonstrate that, if compared to other SNFs or HHAs in its group, it incurs increased costs for services covered by limits under this section because of its operation of an approved education program specified in §413.85.

(5) *Unusual labor costs.* The SNF or HHA has a percentage of labor costs that varies more than 10 percent from that included in the promulgation of the limits.

(f) *Operational review.* Any SNF or HHA that applies for an exception to the limits established under paragraph (e) of this section must agree to an operational review at the discretion of HCFA. The findings from this review may be the basis for recommendations for improvements in the efficiency and economy of the SNF's or the HHA's operations. If recommendations are made, any future exceptions are contingent on the SNF's or HHA's implementation of these recommendations.

[64 FR 42612, Aug. 5, 1999; 65 FR 60104, Oct. 10, 2000]

§413.35 Limitations on coverage of costs: Charges to beneficiaries if cost limits are applied to services.

(a) *Principle.* A provider of services that customarily furnishes an individual items or services that are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services described in §413.30, may charge an individual entitled to benefits under Medicare for such more expensive items or services even though not requested by the individual. The charge, however, may not exceed the amount by which the cost of (or, if less, the customary charges for) such more expensive items or services furnished by such provider in the second cost reporting period immediately preceding the cost reporting period in which such charges are imposed exceeds the applicable limit imposed under the provisions of §413.30. This charge may be made only if—

(1) The intermediary determines that the charges have been calculated properly in accordance with the provisions of this section;

(2) The services are not emergency services as defined in paragraph (d) of this section;

(3) The admitting physician has no direct or indirect financial interest in such provider;

(4) HCFA has provided notice to the public through notice in a newspaper of general circulation servicing the provider's locality and such other notice as the Secretary may require, of any charges the provider is authorized to impose on individuals entitled to benefits under Medicare on account of costs

in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare; and

(5) The provider has, in the manner described in paragraph (e) of this section, identified such charges to such individual or person acting on his behalf as charges to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare.

(b) *Provider request to charge beneficiaries for costs in excess of limits.* (1) If a provider's actual costs (or, if less, the customary charges) in the second preceding cost period exceed the prospective limits established for such costs, the intermediary will, at the provider's request, validate in advance the charges that may be made to the beneficiaries for the excess.

(2) If a provider does not have a second preceding cost period and is a new provider as defined in §413.30(e), the provider, subject to validation by the intermediary, will estimate the current cost of the service to which a limit is being applied. Such amount will be adjusted to an amount equivalent to costs in the second preceding year by use of a factor to be developed based on estimates of cost increases during the preceding two years and published by SSA or HCFA. The amount thus derived will be used in lieu of the second preceding cost period amount in determining the charge to the beneficiary.

(3) To obtain consideration of such a request, the provider must submit to the intermediary a statement indicating the chagre for which it is seeking validation and providing the data and method used to determine the amount. Such statement should include the—

(i) Provider's name and number;

(ii) Identity of class and prospective cost limit for the class in which the provider has been included;

(iii) Amount of charge and cost period in which the charge is to be imposed;

(iv) Cost and customary charge for items and services furnished to beneficiaries; and

(v) Cost period ending date of the second reporting period immediately preceding the cost period in which the charge is to be imposed. The intermediary may request such additional information as it finds necessary with respect to the request.

(c) *Provider charges.*— (1) *Establishing the charges.* If the actual cost incurred (or, if less, the customary charges) in the prior period determined under paragraph (a) of this section exceeds the limits applicable to the pertinent period, the provider may charge the beneficiary to the extent costs in the second preceding cost reporting period (or the equivalent when there is no second preceding period) exceed the current cost limits. (Data from the most recently submitted appropriate cost report will be used in determining the actual cost.) For example, if a limit of $58 per day is applied to the cost of general routine services for the provider's cost reporting period starting in calendar year 1975 and if the provider's actual general routine cost in the second preceding reporting period, that is, the reporting period starting in calendar year 1973, was $60 per day, the provider (after first having obtained intermediary validation and subject to the considerations and requirements specified in paragraph (a) of this section) may charge Medicare Part A beneficiaries up to $2 per day for general routine services.

(2) *Adjusting cost.* Program reimbursement for the costs to which limits imposed under §413.30 are applied in any cost reporting period will not exceed the lesser of the provider's actual cost or the limits imposed under §413.30. If program reimbursement for items or services to which such limits are applied plus the charges to beneficiaries for such items or services imposed under this section exceed the provider's actual cost for such items or services, program payment to the provider will be reduced to the extent program payment plus charges to the beneficiaries exceed actual cost. If the provider's actual cost for general routine services in 1975 was $57,000, the cost limit was $58,000, and billed charges to Medicare Part A beneficiaries were $2,000, the provider would receive $55,000 from the program ($57,000 actual cost minus the $2,000 in charges to the beneficiaries).

(d) *Definition of emergency services.* For purposes of paragraph (a)(2) of this

section, emergency services are those hospital services that are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital (as determined under § 424.106 of this chapter) available and equipped to furnish such services. If an individual has been admitted to such hospital as an inpatient because of an emergency, the emergency will be deemed to continue until it is safe from a medical standpoint to move the individual to another hospital or other institution or to discharge him.

(e) *Identification of charges to individual.* For purposes of paragraph (a)(5) of this section, a provider must give or send to the individual or his representative, a schedule of all items and services that the individual might need and for which the provider imposes charges under this section, and the charge for each. Such schedule must specify that the charges are necessary to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare and include such other information as HCFA considers necessary to protect the individual's rights under this section. The provider, in arranging for the individual's admission, first service, or start of care, must give or send this schedule to the individual or his representative when arrangements are being made for such services or if this is not feasible, as soon thereafter as is practicable but no later than at the initiation of services.

[51 FR 34793, Sept. 30, 1986, as amended at 53 FR 6648, Mar. 20, 1988; 60 FR 45849, Sept. 1, 1995]

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction*—(1) *Scope.* This section implements section 1886(b) of the Act, establishing a ceiling on the rate of increase in operating costs per case for hospital inpatient services furnished to Medicare beneficiaries that will be recognized as reasonable for purposes of determining the amount of Medicare payment. This rate-of-increase ceiling applies to hospital cost reporting periods beginning on or after October 1, 1982. This section also sets forth rules governing exemptions from and adjustments to the ceiling.

(2) *Applicability.* (i) This section is not applicable to—

(A) Hospitals reimbursed in accordance with section 1814(b)(3) of the Act or under State reimbursement control systems that have been approved under section 1886(c) of the Act and subpart C of part 403 of this chapter; or

(B) Hospitals that are paid under the prospective payment systems for inpatient hospital services in accordance with section 1886 (d) and (g) of the Act and part 412 of this chapter.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to hospitals excluded from the prospective payment system in accordance with § 412.23 of this chapter, and psychiatric and rehabilitation units excluded from the prospective payment system in accordance with §§ 412.25 through 412.30 of this chapter.

(3) *Definitions.* As used in this section—

Ceiling is the aggregate upper limit on the amount of a hospital's net Medicare inpatient operating costs that the program will recognize for payment purposes. For each cost reporting period, the ceiling is determined by multiplying the updated target amount, as defined in this paragraph, for that period by the number of Medicare discharges during that period. For a hospital-within-a-hospital, as described in § 412.22(e) of this chapter, the number of Medicare discharges in a cost reporting period does not include discharges of a patient to another hospital in the same building on or on the same campus, if—

(A) The patient is subsequently readmitted to the hospital-within-a-hospital directly from the other hospital; and

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of Medicare inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

Date of discharge is the earliest of the following dates: